MBR

MASSACHUSETTS BUSINESS ROUNDTABLE

February 11, 2009

Special Commission on the Health Care Payment System
Division of Health Care Finance and Policy
Two Boylston Street, 5th floor
Boston, MA 02116

Dear Secretary Kirwan, Commissioner Iselin, and Members of the Special Commission on the Health Care Payment System:

The Massachusetts Business Roundtable (MBR), through our Health Care Task Force, has been engaged in health care reform discussions for more than two decades. The Task Force operates on the premise that all constituencies – employers, consumers, providers, plans and the state – have the shared responsibility for addressing health care costs in Massachusetts. It is in that spirit that we provide these comments to the Special Commission on the Health Care Payment System (Commission).

MBR's Health Care Task Force has released two reports this decade that examine trends in health care spending and offer potential solutions to reduce costs, ideas that have focused on accelerating transparency and financial accountability in the marketplace. The recommendations included in this submission draws heavily from Task Force deliberations, reports, and MBR's long-term vision for the state's health care system.

The Task Force cites a vision for improving the value of the health system articulated by Dr. Robert Galvin (a former chair of the MBR Health Care Task Force) and Dr. Arnold Milstein, who envision a three-stage, decade-long evolution that will lead to substantial reductions in per-capita health spending and improvements in adherence to evidenced-based care. The initial stage of this framework is built on performance disclosure that allows purchasers and consumers to evaluate differences in the cost and quality of competing hospitals and physicians. The second stage envisions a substantial increase in the market's sensitivity to hospital and physician performance. The third stage involves broad-based clinical reengineering by hospitals, physicians and delivery systems. By creating transparency and strong performance-based financial incentives, this strategy aims to create an irrefutable business case for the health care delivery system to engage in the types of clinical restructuring that will achieve significant leaps in quality and efficiency. This is the strategy embraced by MBR's Health Care Task Force.

The work of the initial stage – transparency – is well underway through the creation of the Health Care Quality and Cost Council, the launch of the MyHealthCareOptions website, and other state initiatives. The second phase – consumer and provider incentives – is the natural

next step and consistent with the work of the Commission. In fact, the two phases are not mutually exclusive. For example, financial incentives could play an important role in accelerating provider data reporting.

Critical components for success during the second stage include the retooling of provider reimbursement systems. Following are recommendations from MBR's Health Care Task Force, drawn from its most recent reports. These ideas are shared to both inform your current debate, while also keeping them in the context of a vision for longer-term reform:

1. Pay-for-Performance. Provider reimbursement should be retooled toward a Pay-for-Performance model. A major barrier cited by providers is the lack of a strong business case for providers under current reimbursement structures.[1] For example, one academic medical center reported that a pilot project reduced annual expenses for patients with congestive heart failure from $23,000 to $14,000 – but had "strongly negative financial consequences because it reduced profitable inpatient care while increasing use of poorly reimbursed preventive services."[2]

   Paying providers for performance relative to defined quality goals is a concept with widespread appeal and could lead to expanded investment in quality improvement. A major impediment is that individual health plans may have different standards for quality performance. Moreover, each plan may represent only a small portion of a provider's revenue, making it a difficult business case for individual providers to match performance to all the varying standards. Unless payers can agree on consistent quality measures, reimbursement systems designed to reward quality may have little impact for all but the largest purchasers.

   Massachusetts has a highly concentrated insurance market, with three plans accounting for roughly 80% of commercial enrollment. Financial incentives for improvement could be quite strong if the state's health plans adopted consistent pay-for-performance metrics. The MassHealth program, which accounts for roughly 13% of hospital care in the Commonwealth, does not use pay-for-performance reimbursement. The provider business case for improvement would be strengthened if the state adopted performance incentives consistent with those now used by private health plans.

2. MassHealth Reimbursement Rates. MassHealth reimbursement rates have consistently fallen below the cost of treating Medicaid recipients. When payments from Medicaid or Medicare are insufficient to cover the cost of services, providers attempt to negotiate higher rates with private plans – which may result in a "cost-shift" to private insurance. For each dollar of MassHealth spending, Massachusetts receives one dollar in federal matching funds. From a state economic perspective, setting adequate MassHealth payment rates is more efficient than cost shifting due to federal reimbursement of Medicaid spending. It is important to structure Medicaid reimbursement that creates incentives for economic and efficient delivery of care.

[1] Solutions for Massachusetts Health Care:2006; Massachusetts Business Roundtable; January 2006.

[2] Ibid.

3. Encourage Coordinated Care. Encouraging change in consumer behavior generally requires financial incentives and consequences. However, MBR's Health Care Task Force supports other kinds of incentives as well, including provider incentives to direct high-risk patients to care management programs. Consumers rely on their physician for advice. And while some may argue that managed care's "gatekeeper" model did not work because it was too rigid and narrow, many consumers have benefited from the core concept of managed care, which involves preventive services and care coordination. Certainly, any new payment models need to incorporate and encourage those important care components and care coordination. Capitation programs, and other risk-sharing mechanisms, may best align incentives between the health insurance plans and the provider community. With the proper controls and consideration for the provider's ability to assume risk, this model creates the potential to appropriately manage scarce medical resources and care coordination without compromising quality of care.

4. Private Provider Incentive Systems. A number of purchasers have set up systems to reward doctors and hospitals for excellent care and for investing in infrastructure that has been demonstrated to improve patient safety. Perhaps the most notable program is Bridges to Excellence (BTE), established by General Electric and Verizon Communications. BTE's Board currently includes MBR members EMC, IBM, and Partners Health Care. Physicians that meet the BTE office infrastructure standards, or that demonstrate excellence in specific areas of care, receive an additional payment for each covered patient annually. Perhaps the Payment Reform Commission could find BTE's model for pay-for-performance incentives instructive.

As a group, employers and employees in Massachusetts paid roughly $15 billion for health insurance in 2005. The business community, representing both employers and employees, has a significant investment in the success of health care reform in general, in cost savings initiatives and, more specifically, in the deliberations of your Commission. MBR appreciates the aggressive timeline you have set and welcomes the opportunity to be part of the Commission's deliberations while we collectively work toward a long-term vision for improving the value of the state's health system.

Sincerely,

Alan G. Macdonald
Executive Director